

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>390133</b>		(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>12/08/2022</b>	
NAME OF PROVIDER OR SUPPLIER: <b>LVHN CHILDREN'S SURGERY CENTER</b>  STATE LICENSE NUMBER: <b>24331501</b>				STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1210 SOUTH CEDAR CREST BOULEVARD</b> <b>Suite 3000</b> <b>ALLENTOWN, PA 18103</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
S 0000	<p>INITIAL COMMENT</p> <p>This report is the result of a State Relicensure survey conducted on December 8, 2022, at Lvhn Children's Surgery Center. It was determined the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.</p>			S 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:



# Certified End Page

**LVHN CHILDREN'S SURGERY CENTER**

**STATE LICENSE NUMBER: 24331501**

**SURVEY EXIT DATE: 12/08/2022**

**I Certify This Document to be a True and Correct Statement of Deficiencies and  
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in cursive script that reads "Jeane Parisi".

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

A handwritten signature in cursive script that reads "Debra L. Bogen MD".

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY